EXHIBIT “A”

NEOS
NEW ENGLAND ORTHOPEDIC SURGEONS

Louis M. Adler, MD
Hand, Wrist & Elbow Surgery
Wrist Arthroscopy
J. Stephen Brecht, MD
Trauma and Fracture Care
Complex Fractures
Bennett S. Burns, MD
Trauma & Fracture Care
Complex Fractures
John R. Corsetti, MD
Sports Medicine/Arthroscopy
Shoulder & Knee Surgery
R. Scott Cowan, MD
Spine Surgery
Richard J. Fingeroth, MD
Joint Replacement Surgery
Sumner E. Karas, MD
Shoulder Surgery & Arthroscopy
Robert J. Krushell, MD
Joint Replacement Surgery
Andrew P. Lehman, MD
Joint Replacement Surgery
Martin J. Luber, MD
Sports Medicine/Arthroscopy
Shoulder, Knee & Elbow Surgery
Thomas A. McDonald, MD
Foot & Ankle Surgery
Lois Ann Nichols, MD
Trauma & Fracture Care
Complex Fractures
Joseph H. Sklar, MD
Sports Medicine/Arthroscopy
Knee Surgery
Steven M. Wenner, MD
Hand & Wrist Surgery

John D. DeWeese, MD (retired)
Rollin M. Johnson, MD (1938-2004)
Morton D. Lynn, MD (retired)
Mark H. Pohlman, MD (retired)

Physician Assistants/APRN
Jason J. Asselin, PA-C
Tamer Bahgat, PA-C
Henry J. Casagrande Jr. PA-C
Michael D. Cavanagh, PA-C
Jessica M. Drenga, APRN
Mark A. Dutille, PA-C
Beverly Faille, APRN
Kevin MacPherson, PA-C
Peter A. Michaud, PA-C
Melissa Mol-Pelton, PA-C
Anika Opp-Harris, PA-C
Edward A. Paciti, PA-C
Tracey A. Routenberg, PA-C
Timothy B. Rice, PA-C
Donald C. Salva, PA-C
Amy Warrington, PA-C
Miriam K. Wiggins, PA-C

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November 24, 2008

Thomas J. Joyce
900 Centerton Road
Mt. Laurel, NJ 08054-1630

RE: GEOFFREY CROWTHER
DOB: 05.07.51
OUR ACCT #199336

Dear Attorney Joyce:

Please allow this letter to represent the narrative that you requested on the above referenced individual. As you know, he is claiming that his work as a track laborer, welder, foreman and inspector has contributed to the development of the osteoarthritis in both of his knees.

My relationship with Mr. Crowther began on February 28, 2007. At that point in time, he was having severe pain and disability in regards to both his knees. He was utilizing a cane at that point in time and having difficulty going upstairs as well as getting out of a chair. He was taking over-the-counter pain medication at that point in time.

He subsequently underwent simultaneous bilateral total knee arthroplasty on April 17, 2007 for refractory knee pain secondary to osteoarthritis. Mr. Crowther did extraordinarily well following his elective surgery, and was last evaluated at his annual visit on April 14, 2008. At that point in time, he still had mild discomfort in regards to his left knee, and his right knee was not causing him any significant issues. He essentially was back to normal activities without restriction.

Mr. Crowther has a long history in regards to both of his knees. In fact, according to my records, which were obtained through the patient's history, the patient had an open bilateral meniscectomy back in the 1970's. I believe it was the lateral meniscus that was removed on the right side, and the medial meniscus on the left.

These meniscectomies were performed secondary to a sports related injury, and not related to the patient's employment. Subsequently, in 1986, the patient tore his ACL and subsequently had an open reconstruction with hamstring autograft, I believe. This, according to the patient, was work related. However, I have no paperwork to confirm this.

It is my medical opinion that the causality of Mr. Crowther's osteoarthritis is most likely secondary to these open meniscectomies, 35 years prior to his knee replacement. I understand that he has done a lot of heavy lifting and repetitive strenuous motion in regard to his knees. I also understand that he was exposed to a lot of vibratory stress and overall hard work in his 30 years working on the railroad.

However, the patient did suffer a work related injury in relation to his left ACL. This also may have contributed to a certain extent to this gentleman's development of osteoarthritis. While the majority of this gentleman's arthritis and symptoms are likely from his original sports injuries in 1972, his subsequent ACL injury as well as his difficult occupation likely attributed to some extent into his symptomatology. It is impossible to tell to what extent his work has contributed to the development of osteoarthritis. There is no telling when he would have developed the symptoms of osteoarthritis had he not been exposed to such conditions.

Thus, it is my medical opinion that it is more likely than not that his work conditions have aggravated the symptoms of his osteoarthritis, but his osteoarthritis was caused by his original injuries back in the early 1970's.

As far as permanent impairment is concerned, according to the AMA guides to the evaluation of permanent impairment, 5th Edition, Mr. Crowther has a 15% whole body disability and 37% extremity disability on each knee. I obtained this value from Table 17-33 on page 546. Mr. Crowther has been rated as having a good result following each of his knee replacements and lost points only for some mild discomfort on the left side. By using the combined values chart on page 604, this would give Mr. Crowther a 28% whole body disability in relation to both of his knees, as well as a 60% lower extremity disability.

Mr. Crowther has likely reached maximum medical improvement, now greater than 1 year following his elective surgery, and I expect these impairment ratings to be permanent.

I hope this narrative helps you. If you have any further questions, please call or contact my office.

Signed and sworn to under the pains and penalties of perjury, this 26th day of November 2008.

Sincerely yours,

Andrew P. Lehman, M.D.
Specializing in Knee & Hip Replacement

APL/hh